

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 011830

| | | | |
|--|--|--|---------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Worcester | MARYLAND | STATE Maryland | COUNTY Worcester |
| CITY (If outside corporate limits, write RURAL or and give nearest town) 42 Pocomoke City | LENGTH OF STAY (in this place) 2 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke 42 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 405 Linden Avenue | | STREET ADDRESS (If rural give location) 405 Linden Avenue 1 | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) BEULAH ETTA CAMPBELL | | 4. DATE (Month) (Day) (Year) OF DEATH: Jan. 5, 1956 | |
| 5. SEX: Female | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: May 30, 1871 |
| 9. AGE last birthday 84 yrs. | | 10. AGE last birthday (If under 1 year) (If under 24 hrs.) Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY: Home | |
| 11. BIRTHPLACE (State or foreign country): Maryland | | 12. CITIZEN OF WHAT COUNTRY: U.S.A. | |
| 13. FATHER'S NAME: Robert Henry | | 14. MOTHER'S MAIDEN NAME: Lovie Waters | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, No or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS: Daughter: Elsie Moten, 3736 Hayes St., NE, Washington, D.C. | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) Cerebral Hemorrhage and Convulsions | | 3 weeks | |
| ANTECEDENT CAUSE (B) Cerebral Hemorrhage | | 5 years | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized Arteriosclerosis | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Dec. 13, 1955 to Jan. 5, 1956 that I last saw the deceased alive on Jan. 5, 1956 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE Charles W. Trader | | M.D. Pocomoke City, Md. Jan. 6, 1956 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| Burial | | 1-9-56 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Hall Hillen | | Pocomoke, Md. | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| Jan. 10, 1956 | | Anne E. White | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| Edgar Wharton - New Church, Va. | | | |

BUREAU V. S.

JAN 12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1212

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01184

Reg. Dist. No. 255

| | | | | | | | |
|---|---------------------------|--|--|---|---|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Worcester</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Ocean City</u> | | LENGTH OF STAY (In this place) <u>3 months</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Ocean City</u> | | | |
| TOWN <u>Rural - Ocean City</u> | | | | TOWN <u>Rural - Ocean City</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RT 50</u> | | | | STREET ADDRESS (If rural give location) <u>RT 50 1/4 mile west of Herring Creek</u> | | | |
| 3. NAME OF DECEASED (First) <u>IDA</u> (Middle) <u>(None)</u> (Last) <u>CLARK</u> | | | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>17</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u> | 8. DATE OF BIRTH <u>July 7 1872</u> | 9. AGE last birthday <u>83</u> Yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>William Haverichs</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mrs Beulah Wilson (daughter) Rt 2, Ocean City, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Coronary occlusion acute</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic CVD</u> | | | | 3 years | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Jan 16 1956 2:30 A.M.</u> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 16 1956</u> , to <u>Jan 17 1956</u> , that I last saw the deceased alive on <u>Jan 16 1956</u> , and that death occurred <u>2:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M.D. <u>Ocean City, MD</u> | | ADDRESS (Street, city, town, state) <u>Jan 17, 56</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>I/20/1956</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u> | | LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>JAN 20 1956</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>CHESTERTOWN MD</u> | |

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BUREAU V. S.

1213

CERTIFICATE OF DEATH

Reg. Dist. No. 350

| | | | | | | | |
|---|--------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Worcester | | MARYLAND | | STATE Maryland | | COUNTY Worcester | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Home | | | | STREET ADDRESS R.F.D.# 2 Box 80 | | (If rural give location) | |
| 3. NAME OF DECEASED: (Type or Print) Sarah | | (First) (Middle) (Last) Dennis | | 4. DATE OF DEATH: Jan. 4 | | (Month) (Day) (Year) 19 56 | |
| 5. SEX: F. | 6. COLOR OR RACE: C. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH: Sept. 7, 1893 | 9. AGE last birthday: 62 yrs. | | If UNDER 1 YEAR If UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY: House work | | 11. BIRTHPLACE (State or foreign country): Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: Scott Boston | | | | 14. MOTHER'S MAIDEN NAME: Louise Bell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) -* (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: None | | 17. INFORMANT & ADDRESS: Louise Buttzman Pocomoke, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | Interval Between Onset And Death | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| Immediate cause (a) Chronic Myocarditis | | | | | | | |
| Antecedent causes (s) (b) DUE TO | | | | | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Not While Work <input type="checkbox"/> At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1-4-56 to 1-4-56 , that I last saw the deceased alive on 1-3-56 , and that death occurred at St. James , from the causes and on the date stated above. SIGNATURE E. E. Pitcher (Degree or title) ADDRESS St. James DATE SIGNED 1-7-56 | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF 1/8/56 | | NAME OF CEMETERY OR CREMATORY St James Cem. | | LOCATION (City, town, or county) (State) Pocomoke City, Md. | |
| DATE REC'D BY LOCAL REGISTRAR Jan. 10, 1956 | | REGISTRAR'S SIGNATURE Anne E. White | | 24. FUNERAL DIRECTOR Edgar Wharton - New Church, Va. | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 12 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1210

01186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 350

Reg. Dist.

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Worcester</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Worcester</u> | |
| CITY (if outside corporate limits write RURAL and give nearest town) <u>Pocomoke City</u> | | LENGTH OF STAY (in this place) <u>Life</u> | | CITY (if outside corporate limits write RURAL and give nearest town) <u>Pocomoke City - Rural</u> | | | |
| TOWN | | | | STREET ADDRESS (If rural, give location) <u>Twinn town</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>414 Linden Ave</u> | | | | | | | |
| 3. NAME OF DECEASED: (First) <u>Harrison</u> (Middle) <u>Wendell</u> (Last) <u>Harris</u> | | | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>9th</u> (Year) <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH <u>Jan 20 1913</u> | | 9. AGE last birthday: yrs. <u>42</u> | | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Barber</u> | | 11. BIRTHPLACE (State or foreign country): <u>Pocomoke City MD</u> | | 12. CITIZEN OF WHAT COUNTRY: <u>USA</u> | |
| 13. FATHER'S NAME: <u>Harrison Harris</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Gertrude Cottman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>213-12-6402</u> | | 17. INFORMANT & ADDRESS: <u>Lavinia with St. Pocomoke City MD</u> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONE AND DEATH | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| Immediate cause <u>Probably acute coronary occlusion</u> | | | | | | | |
| DUE TO | | | | | | | |
| Antecedent cause(s) <u>C. alcoholism</u> | | | | | | | |
| (b) Diseases or conditions, if any, giving rise to the above cause <u>20 years</u> | | | | | | | |
| DUE TO | | | | | | | |
| stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>H. E. Sartorius Sr.</u> | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>1-12-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Hall's Hill</u> | | LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Jan 12 1957</u> | | REGISTRAR'S SIGNATURE <u>Anne E. White</u> | | 24. FUNERAL DIRECTOR <u>Edgar Wharton - New Church, Va.</u> | | ADDRESS | |

BUREAU V. S.

JAN 16 1950

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1214

CERTIFICATE OF DEATH

01187

Reg. Dist. No. 353

| | | | | | | | |
|--|------------------|--|-----------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>WORCESTER</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>WORCESTER</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>BERLIN</u> | | | | TOWN <u>BERLIN</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| | | | | <u>N. MAIN ST.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>ADELIA FRANCES HAYWARD</u> | | | | <u>JAN 24 1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>F</u> | <u>W</u> | <u>WIDOW</u> | <u>SEPT. 23, 1867</u> | <u>88</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>HOUSEWIFE</u> | | <u>OWN HOME</u> | | <u>SNOW HILL MD</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>ELIJAH PARSONS</u> | | | | <u>GORDY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>NO</u> | | <u>NO</u> | | <u>MRS. ANTHONY PURNELL, BERLIN MD</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 572.1 IMMEDIATE CAUSE (A) <u>Paralytic Illness due to Peritonitis</u> | | | | | | <u>5 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Perforated Diverticuli of Sigmoid</u> | | | | | | <u>3-4 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis Generalized -</u> | | | | | | <u>10 yrs</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 47</u> , 19 <u>47</u> , to <u>Jan 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Hermark Rahlms</u> | | | | ADDRESS (Street, city, town, state) <u>Berlin, Md</u> | | DATE SIGNED <u>1/26/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>1/27/56</u> | | <u>BUCKINGHAM</u> | | <u>BERLIN MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>Feb. 1, 1956</u> | | <u>Adel F. Hayward</u> | | <u>Anna A. Burbage</u> | | <u>Berlin Md</u> | |

CERTIFICATE OF DEATH

511

DATE OF DEATH

11/20/56

DEATH

W. H. H. H.

ADAM FRANCIS HYMAN

W. H. H. H.

HOWARD E. H. H. H.

EDWARD J. H. H. H.

NO

NO

MR. FRANCIS HYMAN

BUREAU V. 1

FEB 1 1956

RECEIVED

100/20

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01188

1215

CERTIFICATE OF DEATH

Reg. Dist. No. 350

| | | | | | |
|---|--------------------------------|--|---|--|--|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <u>Worcester</u> MARYLAND | | | STATE <u>Maryland</u> COUNTY <u>Worcester</u> | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - Pocomoke, Md.</u> LENGTH OF STAY (In this place) <u>Life</u> | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - Pocomoke, Maryland</u> | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #3</u> | | | STREET ADDRESS (If rural give location) <u>RFD #3</u> | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Samuel Upshur Jones</u> | | | 4. DATE OF DEATH: (Month) (Day) (Year) <u>January 18 19 56</u> | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>February 26, 1874</u> | | 9. AGE last birthday <u>81</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>own</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 13. FATHER'S NAME: <u>George Thomas Jones</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 14. MOTHER'S MAIDEN NAME: <u>Sarah Wise Payne</u> | | | 17. INFORMANT'S ADDRESS: <u>Mrs Ada Jones Burbage Ocean City, Maryland</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY No. <u>None</u> | | |
| 18. MEDICAL CERTIFICATION | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE <u>CARDIAC FAILURE</u> | | | | | <u>Few Minutes</u> |
| (B) ANTECEDENT CAUSE (S): <u>STARVATION</u> | | | | | <u>Few Weeks</u> |
| (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>CARCINOMA of Stomach</u> | | | | | <u>Unknown</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, mod.</u> | | | | | <u>Unknown</u> |
| 19A. DATE OF OPERATION: <u>15 September 1955</u> | | | | | 19B. MAJOR FINDINGS OF OPERATION: <u>CARCINOMA of Stomach - metastases + infiltration inoperable</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 17, 1956</u> to <u>Jan 18, 1956</u> , that I last saw the deceased alive on <u>Jan. 17, 1956</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. | | | | | |
| SIGNATURE <u>Norman E. Sartorius, Jr.</u> | | ADDRESS <u>M.D. Pocomoke, Md.</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Jan 21, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Remson Cemetery</u> | |
| LOCATION (City, town, or county) (State) <u>RURAL-Pocomoke, Maryland</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>Henry H. Watson, Pocomoke, Maryland</u> | | | |
| DATE REC'D BY LOCAL REGISTRAR <u>Jan 21, 1956</u> | | REGISTRAR'S SIGNATURE <u>Anne E. White</u> | | | |

1216

CERTIFICATE OF DEATH

Reg. Dist. No. 355

| | | | |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>WORCHESTER</u> | MARYLAND | STATE <u>MARYLAND</u> COUNTY <u>WORCHESTER</u> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | |
| X TOWN <u>RURAL - BISHOP</u> | <u>2 YRS</u> | <u>RURAL - BISHOP</u> | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| | | <u>BISHOP RD #1</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| (Type or Print) <u>ELEANOR V. LEASURE</u> | | OF DEATH: <u>JAN. 15 1956</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| <u>FEMALE</u> | <u>WHITE</u> | <u>SINGLE</u> | <u>OCT. 28, 1868</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): |
| <u>HOUSEKEEPER</u> | | | <u>MARYLAND</u> |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| <u>JERIMIAH LEASURE</u> | | <u>CAROLINE MACKELFISH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS: | |
| | | <u>MRS. NORMAN HOLLAWAY BISHOP Md RD #1</u> | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| (A) IMMEDIATE CAUSE | | | <u>1 day</u> |
| (B) ANTECEDENT CAUSE (S) | | | <u>3 years</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 19B. MAJOR FINDINGS OF OPERATION | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |
| | | | 21C. WHERE DID (City or town) (County) (State) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |
| | | | 21F. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from ... , 19 ... , to ... , 19 ... , that I last saw the deceased alive on ... , 19 ... and that death occurred at ... M, from the causes and on the date stated above. | | | |
| SIGNATURE <u>Robert G. Gault Jr</u> M.D. <u>Bethesda, Md.</u> DATE SIGNED <u>1/15/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>JAN. 18, 1956</u> | <u>ROSE HILL</u> | <u>CUMBERLAND Md.</u> |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| <u>1-16-56</u> | <u>Helen F. Hayward</u> | <u>Anna A. Benbow</u> | <u>Bethesda Md</u> |

MARGIN RESERVED FOR BINDING

BUREAU V. 2

JAN 19 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1211

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01156

CERTIFICATE OF DEATH

Reg. Dist. No. 350

| | | | | | | | |
|--|----------------------------------|--|---|---|--------------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Worcester | | MARYLAND | | STATE Maryland | | COUNTY Worcester | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) Pocomoke | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Home | | | | STREET ADDRESS (If rural give location) 403 Oxford St. | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) Polly Selby | | | | 4. DATE OF DEATH: (Month) (Day) (Year) Jan. 2, 1956 | | | |
| 5. SEX: Female | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH: March 2, 1890 | 9. AGE last birthday 65 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Mins. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY: Housework | | 11. BIRTHPLACE (State or foreign country): Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: Henry Wallop | | | | 14. MOTHER'S MAIDEN NAME: Mary Hickman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: Howard Wallop - Oak Hall, Va. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE | | (A) Congestive Heart Failure | | | | 2 days | |
| ANTECEDENT CAUSE (B) | | (B) Hypertension | | | | app. 8 mos. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | (C) Generalized Arteriosclerosis | | | | ? | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Nov 1955 , to Jan 2, 1956 , that I last saw the deceased alive on Jan 1, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Deceased J. F. Fletcher | | M.D. Worcester, Va. | | DATE SIGNED Jan 4, 1956 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried | | DATE THEREOF Jan 7-56 | | NAME OF CEMETERY OR CREMATORY Wattsville Cem. | | LOCATION (City, town, or county) (State) Wattsville, Va. | |
| DATE REC'D BY LOCAL REGISTRAR Jan 10, 1956 | | REGISTRAR'S SIGNATURE Anne E. Thet | | 24. FUNERAL DIRECTOR Edgar Wharton | | ADDRESS New Church, Va. | |

105-105

105-105

105-105

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01191

1217

Item 1, Film 8191 133-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 357

| | | | |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Worcester MARYLAND | | STATE Md. COUNTY Worcester | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS --- | | STREET ADDRESS (If rural give location) --- | |
| 3. NAME OF DECEASED: (Type or Print) | | 4. DATE OF DEATH: | |
| (First) Maggie Belle (Middle) Smith (Last) | | (Month) Jan. (Day) 2 (Year) 1956 | |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow | 8. DATE OF BIRTH: Sept 12, 1869 |
| 9. AGE last birthday: 86 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | 11. BIRTHPLACE (State or foreign country): Newark, Md. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY: Home | |
| 11. CITIZEN OF WHAT COUNTRY? U.S. A. | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME: Loda Davis | | 14. MOTHER'S MAIDEN NAME: Emma ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT'S ADDRESS: Mr. Wilmer L. Smith Newark, Md. | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) Hypertensive Arteriosclerosis | | DUE TO | |
| ANTECEDENT CAUSE (B) Cardio renal disease | | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: 0 | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) (Minute) | |
| 21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 1953 , 19... to 1/2/56 , 19..., that I last saw the deceased alive on 12/31/55 , 19... and that death occurred at M. from the causes and on the date stated above. | | | |
| SIGNATURE Paul Cohen | | ADDRESS Snow Hill Md | |
| DATE SIGNED 1-4-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/5/56 | |
| NAME OF CEMETERY OR CREMATORY Evergreen Cem | | LOCATION (City, town, or county) (State) Berlin Md. | |
| DATE REC'D BY LOCAL REGISTRAR Jan 5, 56 | | REGISTRAR'S SIGNATURE Samuel C. Cooper | |
| 24. FUNERAL DIRECTOR Anna A. Bumbay | | ADDRESS | |

BUREAU V. S.

JAN 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN, HOSPITAL, OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01192

1218

CERTIFICATE OF DEATH

Reg. Dist. No. 351

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Worcester</u> | | STATE <u>Md</u> COUNTY <u>Worcester</u> | | CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Snow Hill Rural #1</u> | | CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Snow Hill Rural #1</u> | |
| CITY OR TOWN <u>Snow Hill Rural #1</u> | | LENGTH OF STAY (in this place) | | STREET ADDRESS | | (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Robert H. Victor</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 8 1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Caucasian</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>June 15/1866</u> | |
| 9. AGE last birthday <u>90 5/6</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 11. BIRTH PLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Jacob Victor</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS <u>Mrs. Seaford Victor, Snow Hill, Md</u> | | 18. MEDICAL CERTIFICATION | | 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 10/20, 1955, to 1/8, 1956, that I last saw the deceased alive on 1/4, 1956, and that death occurred at 7:45 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Thomas E. Jones, MD</u> | | | | DATE SIGNED <u>1/9/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24. REC'D BY REGISTRAR | | | |
| DATE THEREOF <u>Jan. 12/56</u> | | | | REGISTRAR'S SIGNATURE <u>Clara E. Cooper</u> | | | |
| NAME OF CEMETERY OR CREMATORY <u>Coalspring Cemetery</u> | | | | LOCATION (City, town, or county) <u>Chillicothe, Md</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Dennis</u> | | | | ADDRESS <u>Snow Hill, Md</u> | | | |

CERTIFICATE OF DEATH

1913

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

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AGE

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EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

BUREAU V. S.

JAN 13 1913

RECEIVED